

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007138

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1171

FILED MAR 15 1963

VS 300
Rev. 4/591
270042

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DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Clint L. Miller, M.D. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mo. b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN Lee's Summit	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hosp.		d. STREET ADDRESS (If outside, give location) 6120 Lake Lotawana	
3. NAME OF DECEASED (Type or print) First Mabel Middle Lucile Last Whitacre		4. DATE OF DEATH Month Feb. Day 20 Year 1963	
5. SEX FEMALE	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and state or country) Jesup - Iowa	
13a. FATHER'S NAME FRANK L. LIZER		14. NAME OF HUSBAND OR WIFE John L. Whitacre	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		16. SOCIAL SECURITY NO. 56	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Cholesterol Heart Disease DUE TO (c) 3 yr		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia - two weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 10-8-1958 to 2-20-63 and last saw her alive on 2-20-63 Death occurred at 10:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or informant) Clint L. Miller M.D.		22b. ADDRESS Lee's Summit Mo.	
22c. DATE SIGNED 2-21-63		22d. LOCATION (City, town, or county) (State) Raytown Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE Feb. 22, 1963	
23c. NAME OF CEMETERY OR CREMATORY Brookings Cemetery		23d. LOCATION (City, town, or county) (State) Raytown Mo.	
24. FUNERAL DIRECTOR Hinton Funeral Home		25. DATE RECD. BY LOCAL REG. 2-21-63	
26. REGISTRAR'S SIGNATURE Ruth Long			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Forest D. Coldman

Licensed Embalmer No. 7714

P. O. Address

R. C. W. Co.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.